STATE OF MICHIGAN

IN THE SUPREME COURT

CYNTHIA HARDY, Personal Representative of the Estate of MARGARET MARIE ROUSH,

Plaintiff-Appellee,

v

LAURELS OF CARSON CITY, LLC,

Defendant-Appellant.
_____/

Supreme Court Case No. 150882

Court of Appeals Case No. 317406

Montcalm County Circuit Court
Case No. 2012-016830-CZ

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STATEMENT OF APPELLATE JURISDICTION

The Court has jurisdiction to hear this appeal of the Court of Appeals judgment entered on December 11, 2014, under MCR 7.301(A)(2). The Laurels of Carson City, L.L.C. timely applied for leave to appeal on January 21, 2015. The Court ordered oral argument on whether to grant the application for leave to appeal on September 18, 2015.

The Court of Appeals had jurisdiction under MCR 7.203(A)(1) to hear and decide the Estate of Margaret Roush's appeal from the Montcalm County Circuit Court's December 11, 2014 Opinion and Order granting summary disposition on all claims in favor of Defendant. In her capacity as the personal representative of the Estate of Margaret Roush, Cynthia Hardy timely appealed the circuit court's judgment on July 25, 2013.

STATEMENT OF QUESTIONS PRESENTED

1. Did the Court of Appeals correctly determine that summary disposition on the Estate of Margaret Roush's false-imprisonment claim and related tort claims should be reversed where a nursing home confined an adult, who has never been adjudicated to be incompetent, against her will?

Plaintiff/Respondent Estate of Margaret Roush answers: Yes

Defendant/Petitioner Laurels of Carson City, L.L.C. answers: No

Court of Appeals answered: Yes

2. Did the Court of Appeals err by relying upon an affidavit submitted by the Estate of Margaret Roush's counsel to conclude that genuine issues of material fact remained?

Plaintiff/Respondent Estate of Margaret Roush answers: No

Defendant/Petitioner Laurels of Carson City, L.L.C. answers: Yes

The Court of Appeals did not address this issue because Laurels did not argue that either the circuit court or the Court of Appeals should not rely upon counsel's affidavit.

3. Did the Court of Appeals err by addressing the Estate of Margaret Roush's claims for intentional infliction of emotional distress, abuse of process, and civil conspiracy?

Plaintiff/Respondent Estate of Margaret Roush answers: No

Defendant/Petitioner Laurels of Carson City, L.L.C. answers: Yes

Court of Appeals answered: No

REASONS FOR DENYING THE APPLICATION AND INTRODUCTION

This case arises after a nursing home, Defendant Laurels of Carson City, L.L.C., refused to discharge Plaintiff Margaret Roush, [1] a 98-year-old woman, contrary to her oft-repeated wishes. Ms. Roush was only freed after a probate court ordered Laurels to allow Ms. Roush to attend a guardianship hearing, where the probate court indicated that Ms. Roush was free to decide for herself whether to return to Laurels. She valued her liberty, and went home to live with her family.

Ms. Roush's problems began after Laurels determined that she was incapable of making medical decisions for herself, which gave her designated patient advocate, Robert Gallagher, authority to act on her behalf. Under the Estates and Protected Individuals Code, Mr. Gallagher's authority automatically lapsed when Ms. Roush regained the ability to make medical decisions for herself. MCL 700.5509(2). Ms. Roush regained her capacity to make medical decisions at some point a few weeks later. Nonetheless, Laurels would not release her without Mr. Gallagher's approval.

Ms. Roush revoked her patient advocate designation, as she was entitled to do under EPIC even if she was incapable of making medical decisions. MCL 700.5510(1)(d). Laurels has acknowledged that after the revocation, Ms. Roush no longer had a patient advocate. But Laurels continued to refuse to follow Ms. Roush's direction to release her.

Laurels's medical director conducted a mental-status examination that showed that Ms. Roush's mental status was not impaired. But the doctor felt that Ms. Roush did not fully

[1] Ms. Roush initiated this case a few weeks after being released by Laurels. Several months later, she died. The litigation has been continued by the personal representative of Ms. Roush's estate. For ease of reference, and because Ms. Roush was the victim of Laurels's actions, the Plaintiff/Respondent here will be referred to as Ms. Roush.

understand the potential ramifications of going home to be with her family, so Laurels refused to allow her to leave—even to attend the hearing on her petition for a writ of habeas corpus.

Laurels ultimately freed Ms. Roush after the probate court directed Laurels to allow Ms. Roush to attend a guardianship hearing. At that hearing, Ms. Roush's guardian ad litem accurately summarized the situation: "We have a woman whose liberty interests are being compromised based on the opinion of one doctor." (Ex 7, Guardianship Hr'g Tr 5.) The probate court declared that it was Ms. Roush's decision whether to go home. (*Id.* at 13.) Weeks after Ms. Roush directed Laurels to release her, Ms. Roush finally went home.

Ms. Roush sued Laurels for false imprisonment and several other torts based on its confinement of her in violation of her fundamental rights to liberty and freedom of movement. Laurels has argued that the patient-advocate provisions in EPIC make it immune from liability. EPIC does no such thing; it merely provides a mechanism for obtaining a judicial determination of whether a patient is capable of participating in medical decisions where the patient has an unrevoked patient advocate designation. Laurels never initiated any proceeding to obtain such a ruling. Instead, it steadfastly refused to allow Ms. Roush to leave—even to attend court proceedings about her mental status.

Despite the absence of any statutory basis excusing Laurels's confinement of Ms. Roush against her wishes, the circuit court accepted Laurels's argument and granted its motion for summary disposition. The Court of Appeals reversed, citing numerous factual issues and noting that EPIC does not resolve the issues raised by Ms. Roush's tort claims. The Court of Appeals' decision is correct because factual issues preclude the entry of summary disposition, and because the circuit court's ruling is wrong as a matter of law. Its decision should not be reversed.

This case could raise important questions regarding the liberty interests of nursing-home patients, the authority of patient advocates, and the liability of a nursing home for depriving a patient of her liberty based on a doctor's opinion that a patient is better off in a nursing home than at home with her family. But this case is not an adequate vehicle for addressing those issues because the record is incomplete. Numerous factual allegations that are key to the proper resolution of this case are only the assertions of counsel. For example, most of the purported facts regarding Laurels's decisions and Ms. Roush's medical condition are based on assertions by Laurels's counsel or allegations in pleadings, not record evidence. Moreover, as the Court of Appeals identified in its unpublished decision, there are numerous unresolved factual disputes. For that reason, the Court of Appeals did not address the legality of Laurels's conduct under EPIC and the common law. Accordingly, Ms. Roush respectfully submits that the Court should deny leave to appeal and allow the case to proceed in the circuit court.

COUNTERSTATEMENT OF FACTS

The parties agree that the material facts that the courts should consider on a motion for summary disposition are limited to those that are actually supported by admissible evidence, and that the facts must be construed in the light most favorable to Ms. Roush, the non-moving party. (Laurels's Appl'n 9.) Laurels's factual presentation honors these rules more in the breach than in the observance. For example, the three full paragraphs on page 2 of the Application have no evidentiary support in the record. The same is true for the two full paragraphs on page 3, and the only full paragraph on page 4. Accordingly, Ms. Roush sets forth the following counter-statement of facts with specific record citations.

Record evidence of Ms. Roush's confinement at Laurels against her will

In 2010, Ms. Roush executed a patient advocate designation identifying Robert Gallagher as her patient advocate. (Ex 1, Patient Advocate Designation.) The form inconsistently left the designation of a successor patient advocate blank but was executed by Cynthia Hardy, Ms. Roush's granddaughter, as the successor patient advocate on the same day the patient advocate designation was executed by Ms. Roush. (*Id.* at 7, 11.)

In mid-October 2012, Ms. Roush was receiving care at Laurels. (See Laurels's Appl'n Ex C, Laurels's Ans to Pet for Writ of Habeas Corpus Exs B-C, Decision Making Capacity Forms (demonstrating that Ms. Roush was at Laurels).) On October 24, 2012, Laurels's attending physicians determined that Ms. Roush was not capable of making medical and financial decisions. (*Id.*) Accordingly, on that date, Ms. Roush's designation of Mr. Gallagher as her patient advocate became effective. (See Ex 1, Patient Advocate Designation.)

Within two weeks, Ms. Roush began to demand to be discharged from Laurels so she could return home. (Ex 2, Hardy Aff 1.) Laurels did not honor these demands, so on November 13, 2012, Ms. Roush's daughter, Christine Olds, and Ms. Hardy went to Laurels with two police officers to seek Ms. Roush's release. (Ex 3, Millard Aff, Ex 2 Police Report 4.) The officers spoke with Ms. Roush and believed she was mentally fit. (*Id.* at 5.) Laurels informed the officers that because Ms. Roush had been deemed incapable of making medical decisions, Ms. Roush could only leave if Mr. Gallagher allowed it. (*Id.*) The officers left Laurels that day with the impression that Mr. Gallagher would allow Ms. Roush to return to her home. (See *id.* at 6.) That did not occur.

Two days later, Ms. Roush met with her attorney, Scott Millard, and in writing, revoked the designation of Mr. Gallagher as her patient advocate. (Ex 8, Revocation.) After receiving the revocation, Laurels acknowledged that "there is no patient advocate for somebody who has

been determined by 2 different physicians to be incapable of making and communicating medical and financial decisions . . . ." (Ex 4, 6/25/2013 Hr'g Tr 8. See also Laurels' Appl'n Ex C, Laurels's Ans to Pet for Writ of Habeas Corpus ¶ 5 (Laurels "does not currently know who, if anyone, has the right to make medical decisions on behalf of Mrs. Roush including the right to determine that she should be discharged Against Medical Advice.").) But Laurels still refused to follow Ms. Roush's directive to discharge her.

That night, Dr. Robert Seals, Laurels's medical director, reassessed Ms. Roush's ability to participate in making decisions about her own medical care. (Ex 5, 11/15/2012 Progress Note.) Dr. Seals acknowledged that Ms. Roush wanted to go home, but noted that he "feels" that Ms. Roush does not understand the ramifications of her decision to leave Laurels, and was "concerned that going home would be risky." (*Id.* at 1.) Dr. Seals administered a mental status test to Ms. Roush, but scored it incorrectly, understating her mental status. (Compare *id.* (stating Ms. Roush scored 19 out of 30) with *id.* at 2 (Folstein Mini-Mental Status examination correctly scored at 21).) Dr. Seals asserted that Ms. Roush's score was "consistent with impairment" (*id.* at 1), contrary to the test itself, which indicates that scores of *less than 19* demonstrate impairment (*id.* at 3). The objective test results contradicted Dr. Seals's feeling that Ms. Roush was incapable of making medical decisions for herself.

The next morning, Ms. Roush petitioned the Montcalm County Circuit Court for a writ of habeas corpus to free her from Laurels. (See Laurels's Appl'n Ex C, Laurels's Ans to Pet for Writ of Habeas Corpus.) In response, Laurels did not contend that they were not preventing Ms. Roush from leaving contrary to her wishes. (See generally, *id.*) Instead, Laurels claimed it did not "know who, *if anyone*, has the right to make medical decisions on behalf of Mrs. Roush including the right to determine that she should be discharged." (Ex C, Laurels's Ans to Pet for

Writ of Habeas Corpus ¶ 5 (emphasis added).) The circuit court did not have the opportunity hear testimony from Ms. Roush because Laurels indicated that Ms. Roush's condition was so tenuous that she should not attend. (Ex 4, 6/25/2013 Hr'g Tr 30.) The circuit court denied the petition, and believed that the probate court was better situated to determine Ms. Roush's competency. (Laurels's Appl'n Ex D, Order Denying Writ of Habeas Corpus.)

For the next five days, Laurels continued to prevent Ms. Roush from leaving. (See Ex 6, Heath Aff; Ex 2, Hardy Aff.) Laurels even went so far as to prepare paperwork for Mr. Gallagher to petition the probate court to appoint him as Ms. Roush's guardian. (See Ex 6, Heath Aff 1.)

When the time came for the hearing on the petition, Laurels refused to allow Ms. Hardy to take Ms. Roush to the hearing. (Ex 2, Hardy Aff 1.) Again Laurels was unwilling to allow Ms. Roush to appear before the court. (*Id.*) Ms. Roush's attorney filed a motion to show cause against Laurels, and the probate court directed Laurels to produce Ms. Roush. (Ex 6, Heath Aff 1.)

The testimony before the probate court demonstrated that there was no basis to impose a temporary guardian. Mr. Gallagher testified that Ms. Roush wanted to go home, that he was in favor of it, but the doctors told him she should not go home. (Ex 7, Guardianship Hr'g Tr 4.) And Mr. Gallagher testified that Ms. Roush was currently competent, and suggested that she had been for at least the preceding two weeks. (See *id.* at 7.) Ms. Roush's guardian ad litem opposed any guardianship, explaining that the court was faced with "a woman who[se] liberty interests are being compromised based on the opinion of one doctor." (*Id.* at 5.) The guardian ad litem believed Ms. Roush was competent. (*Id.*) The probate court found no basis to impose an emergency guardianship. (*Id.* at 8.)

During the hearing, Ms. Roush informed the probate court that she wanted to end Mr. Gallagher's patient advocacy. (*Id.* at 13.)

At the end of the hearing, Mr. Gallagher inquired whether Ms. Roush would be returned to Laurels. The court informed him that Ms. Roush was her own boss, and it was her decision whether to go home. (*Id.*) For that reason, on November 21, 2012, Ms. Roush was finally free to return to her home. (See Ex 6, Heath Aff 2.)

A few weeks later, Ms. Roush sued Laurels for false imprisonment, intentional infliction of emotional distress, abuse of process, and civil conspiracy. (Compl.)

The circuit court grants summary disposition to Laurels

Laurels moved for summary disposition before discovery was completed. (See Roush's Resp in Opp'n to Laurels' Mot for Summ Disp 3-4.) In Ms. Roush's opposition to Laurels' motion, she submitted an affidavit from her counsel identifying various factual issues that needed to be developed by further discovery, including when Ms. Roush was actually incapable of participating in decisions regarding her medical care. (Ex 3, Millard Aff.) Laurels never objected to any aspect of counsel's affidavit in the circuit court.

The circuit court granted summary disposition to Laurels because the court believed that Laurels acted appropriately under MCL 700.5508(2). (Ex 4, 6/25/2013 Hr'g Tr 32.) On this basis alone, the court entered judgment in favor of Laurels on all four counts of Ms. Roush's complaint. (See *id.* at 32.)

The Court of Appeals reverses and remands for further proceedings

Ms. Roush appealed the circuit court's decision, asserting that the circuit court's reasoning was in error, and requesting reversal of the trial court's decision. On appeal, Laurels did not raise any objection to the affidavit from Attorney Millard. The Court of Appeals

ultimately relied upon that affidavit to identify factual issues on which additional discovery was necessary. (COA Op 2-3.) The Court of Appeals reversed the circuit court in an unpublished decision.

STANDARD OF REVIEW

The Court reviews de novo a trial court's grant of summary disposition under MCR 2.116(C)(10). *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999).

ARGUMENT

I. The Court of Appeals correctly reversed the grant of summary disposition by the circuit court.

Throughout this case, Laurels has argued that it was entitled to ignore Ms. Roush's demands to be released from Laurels because it determined that she was incapable of making medical decisions for herself, and thus only her designated patient advocate could require Laurels to free her. Laurels claims it is not subject to liability for depriving Ms. Roush of her liberty because MCL 700.5508(2) provides for judicial resolution of conflicts regarding whether a patient advocate's powers are effective. The circuit court adopted Laurels's argument. The Court of Appeals did not.

The Court of Appeals' decision is correct for three reasons. First, MCL 700.5508(2) does not resolve this dispute because Laurels never obtained a judicial determination that Ms. Roush was incapable of participating in her own medical decisions, and Ms. Roush unequivocally revoked her patient advocate designation. Nonetheless, Laurels continued to refuse to comply with Ms. Roush's commands to release her. Second, genuine issues of material fact exist regarding whether Ms. Roush was incapable of making medical decisions for herself. Third, the Public Health Code grants nursing home patients the right to discharge themselves unless the

patient is subject to a guardianship. For each of these independently valid reasons, the Court of Appeals' decision should not be reversed.

A. The Court of Appeals correctly reversed the circuit court's ruling.

The circuit court ruled that because it believed "Laurels of Carson City did what they should do in terms of seeking some sort of legal determination" under MCL 700.5508(2), all of the claims should be dismissed. (Ex 4, 6/25/2013 Hr'g Tr 32.) The court did not explain how continuing to confine Ms. Roush without a judicial determination that she could neither participate in medical decisions nor revoke her patient advocate designation was lawful. Accordingly, the Court of Appeals correctly reversed the circuit court's ruling.

Generally, a person retains the right to choose the type and course of his or her medical treatment. That right is grounded in three sources: 1) the common-law right to freedom from unwanted interference with bodily integrity; 2) the constitutional right to privacy or liberty; or 3) statute. *In re Martin*, 450 Mich 204, 215; 538 NW2d 399 (1995) (citation omitted). Because an individual's right of self-determination generally outweighs any countervailing state interests, a competent person's direction generally controls a patient's medical care "regardless of the consequences of that decision." *In re Martin*, 200 Mich App 703, 711; 504 NW2d 917 (1993). This includes a person's decision not to consent to medical treatment. See *Martin*, 450 Mich at 216.

EPIC provides that an individual may designate a patient advocate to make medical decisions for the individual when the individual is determined to be incapable of participating in medical decisions. MCL 700.5506-.5507. In consideration of the patients' rights of self-determination, EPIC includes a panoply of patient protections.

The patient advocate's authority only becomes effective after the patient's attending physician and another physician or psychologist examine the patient and determine that the patient is unable to participate in medical treatment decisions. MCL 700.5508(1). The determination must be put in writing and be included in the patient's medical record. *Id.*

The powers of a patient advocate lapse if the patient regains the ability to participate in medical decisions. MCL 700.5509(2). There is no need for medical personnel to certify that a person is able to participate in medical decisions—once the patient regains that ability, the patient advocate's authority is suspended. *Id.* The patient advocate's authority can be reinstated only after a new examination by two physicians. See *id.*

Most importantly, a patient can revoke a patient advocate designation at any time, and in any manner, even if the attending medical personnel and patient advocate believe that the patient lacks the ability to participate in medical decisions. MCL 700.5510(d). EPIC states "even if the patient is unable to participate in medical treatment decisions, a patient may revoke a patient advocate designation at any time and in any manner by which he or she is able to communicate an intent to revoke the patient advocate designation." *Id.* When the patient's medical personnel or health facility receives notice of the revocation, the medical personnel or health facility are obligated to note the revocation in the patient's medical record and inform the now-former patient advocate. *Id.* The EPIC Reporter's Comment notes that the patient is given a "supranormal authority" to revoke the designation of a patient advocate even when the patient is not competent to participate in medical treatment decisions. *Michigan Probate Sourcebook* (3d ed), § 700.5510, reporter's comment.

EPIC does not allow a health facility to make medical decisions for a person who does not have a patient advocate and who the treating physician believes to be incapable of making

medical decisions. To the extent a health facility believes an individual is incompetent, it is free to petition the courts to appoint a guardian. As a consequence, in the absence of a court-appointed guardian, a patient who revokes a patient advocate designation regains her legal rights to consent or not consent to medical care.

Finally, the Legislature provided that if a dispute arises regarding a patient's ability to participate in medical decisions where there is a patient advocate, "a petition may be filed with the court in the county in which the patient resides or is located requesting the court's determination as to whether the patient is unable to participate in decisions regarding medical treatment." MCL 700.5508(2). Nothing in EPIC grants immunity from tort liability to a nursing home holds a patient against the patient's will pursuant to the direction of a patient advocate whose authority has been suspended or whose designation has been revoked. To the contrary, MCL 700.5508(2) sets forth an optional process for obtaining judicial resolution. *Id.* ("a petition *may* be filed" (emphasis added)).

Without any textual basis, the circuit court adopted Laurels' reasoning that if a dispute arises regarding a patient's ability to participate in a medical decision, the only avenue for resolving that dispute is by seeking a judicial determination under MCL 700.5508(2), and that this process immunizes healthcare providers from tort liability. The circuit court's ruling is all the more incongruous given that Laurels never obtained a ruling that Ms. Roush was incapable of participating in medical decisions, or that Ms. Roush's revocation of her patient advocate designation was ineffective. Laurels could have filed a petition to obtain a ruling on those issues after being confronted by police officers, Ms. Roush's lawyers, and its own test demonstrating that Ms. Roush's mental status was not impaired. It did not. Indeed, it impeded courts from being able to examine Ms. Roush in person. (Ex 6, Heath Aff 1; Ex 4, 6/25/2013 Hr'g Tr 30.)

Accordingly, the Court of Appeals correctly reversed the circuit court's decision because MCL 700.5508(2) does not resolve any of the issues in the case. (COA Op 3 (false imprisonment), 4 (intentional infliction of emotional distress), 5 (abuse of process, civil conspiracy).)

B. The Court of Appeals correctly reasoned that genuine issues of material fact precluded summary disposition in favor of Laurels.

The Court of Appeals reversed the circuit court's decision granting summary disposition in favor of Laurels on Ms. Roush's wrongful-imprisonment claim because genuine issues of material fact exist as to whether Ms. Roush was unable to participate in decisions regarding her own medical care. (COA Op 2-3, 4, 5.) If Ms. Roush was entitled to participate in decisions regarding her medical care at any time between November 8, 2012, and November 21, 2012, when she required her freedom of movement, there was no basis for Laurels to defer to Mr. Gallagher and refuse to honor Ms. Roush's direction to release her.

The Court of Appeals identified three factual issues that precluded entry of summary disposition in favor of Laurels: whether Ms. Roush was capable of participating in medical decisions on October 24, 2012; whether Ms. Roush regained the ability to participate in her medical decisions sometime before her release; and whether Ms. Roush validly revoked her patient advocate designation. (COA Op 2-3.) None of these factual issues are resolved by MCL 700.5508(2). (*Id.* at 3.) Each of these factual issues is a sufficient basis to remand the case to the circuit court for the completion of discovery.

1. The Court of Appeals' conclusion that summary disposition could not be granted on this record is clearly supported with regard to whether Ms. Roush validly revoked her patient advocate designation. As discussed above, a patient may revoke a patient advocate designation at any time and in any manner that communicates an intent to do so, *even if the patient is unable to participate in medical treatment decisions*. MCL 700.5510(1)(d). Section 5515 of EPIC

provides that a patient can waive the right to revoke a patient advocate designation, but Ms. Roush did not do so. MCL 700.5515. To the contrary, she specifically reserved the right to revoke her patient advocate designation at any time in any manner in which she is able to communicate. (Ex 1, Patient Advocate Designation 9.)

The record shows that on November 13, 2012, Ms. Roush met with her attorney and explicitly revoked her patient advocate designation in writing. (Ex 8, Revocation.) That night, Laurels administered a mental capacity test that demonstrated that Ms. Roush's mental capacity was not impaired. (Ex 5, 11/15/2012 Progress Note 2-3.) Laurels has never offered any evidence that Ms. Roush did not validly revoke her patient advocate designation. Indeed, at the summary-disposition hearing, Laurels admitted that after the revocation, "we have a situation . . . where there is no patient advocate." (Ex 4, 6/25/2013 Hr'g Tr 8.) Ms. Roush reiterated her intent to end Mr. Gallagher's involvement in her affairs at the probate court hearing. (Ex 7, Guardianship Hr'g Tr 8.)

Accordingly, despite Laurels' continued feeling that Ms. Roush did not fully understand the ramifications of her decision to leave Laurels, it was duty bound to allow Ms. Roush to leave. To the extent the Court of Appeals erred, it was in suggesting that there was any record evidence from which Laurels could dispute Ms. Roush's revocation.

2. Under EPIC, Mr. Gallagher's power to control Ms. Roush's medical care lapsed when Ms. Roush regained the ability to participate in those decisions. MCL 700.5509(2). The record evidence preponderates greatly in favor of the conclusion that from November 8-21, 2012, Ms. Roush had regained the capability to participate in medical decisions:

- Ms. Hardy averred that by the beginning of November 2012, Ms. Roush was capable of expressing her own wishes and demanded to return home. (Ex 2, Hardy Aff 1.)

- Mr. Gallagher testified at the guardianship hearing that Ms. Roush was competent, and was "talking sensible" for the preceding two weeks (i.e. back to November 7, 2012). (Ex 7, Guardianship Hr'g Tr 7.)

- The police officers who visited with Ms. Roush on November 13, 2012, believed that Ms. Roush was mentally fit and seemed to know exactly what was going on. (Ex 3, Millard Aff, Ex 2 Police Report 5.)

- Ms. Roush's counsel met with her on November 15, 2012, and spoke with her on November 21, 2012, and concluded that she was competent and of sound mind. (Ex 4, 6/25/2013 Hr'g Tr 9; Ex 6, Heath Aff 1.)

- Dr. Seals performed a mental status test on Ms. Roush on November 15, 2012, which demonstrated that her mental state was not impaired. (Ex 5, 11/15/2012 Progress Note 2-3.)

- Ms. Roush's guardian ad litem met with her on Monday, November 19, 2012, and concluded that Ms. Roush was oriented as to time and place, including current events and the then-recent presidential election. (Ex 4, 6/25/2013 Hr'g Tr 6.) The guardian ad litem concluded that Ms. Roush's "liberty interests are being compromised based on the opinion of one doctor." (*Id.* at 5.)

- After hearing evidence and observing Ms. Roush in the courtroom on November 21, 2012, the probate court concluded that the evidence demonstrated that Ms. Roush was competent, and she was entitled to decide whether to return to Laurels. (*Id.* at 10, 13-14.)

The only contrary record evidence is the determination from Laurels' medical staff on October 26, 2012, and Dr. Seals's progress note from November 15, 2012, in which he expressed his feeling that Ms. Roush was not able to "fully understand[] the potential ramifications of her decisions." (Ex 5, 11/15/2012 Progress Note 1.)

Thus, the record amply supports the Court of Appeals' determination that factual issues exist regarding whether Ms. Roush regained the ability to participate in medical decisions.

3. The Court of Appeals' determination that there are factual issues regarding whether Ms. Roush was capable of participating in medical decisions on October 26, 2012, is based upon the affidavit submitted by Attorney Millard. (See Ex 3, Millard Aff 2.) Attorney

Millard averred that he anticipated that Dr. Seals's testimony would show that Ms. Roush "was able to participate in making medical decisions, but that he disagreed with her desires." (*Id.*) The Court of Appeals viewed this evidence in the light most favorable to Ms. Roush, as the nonmoving party, to conclude that it created a genuine issue of material fact that Ms. Roush was able to participate in medical decisions even on October 26, 2012. (COA Op. 2.) This is the only factual dispute identified by the Court of Appeals that Laurels contested in its Application for Leave. (Laurels' Appl'n 15-16.) Given that discovery was not complete, the Court of Appeals' conclusion should not be reversed. But this determination is not necessary to sustain the Court of Appeals' determination because the other factual issues are sufficient to preclude summary disposition on the entire period of Ms. Roush's false imprisonment.

Given the support for the Court of Appeals' conclusions and because discovery is not complete, the Court should deny leave to appeal and allow the case to return to the circuit court for the completion of discovery. In the alternative, the Court of Appeals' decision should be affirmed.

C. Summary judgment in favor of Laurels is contrary to the Public Health Code.

The Public Health Code provides that nursing home patients have the right to discharge themselves from the nursing home. MCL 333.20201(3)(d). Ms. Roush repeatedly asked to be discharged, but Laurels refused.

Laurels contends that because a patient advocate "may" exercise this right, a patient who is subject to the authority of a patient advocate may not. (Laurels's Appl'n 18 n 2.) But the statutory provision that grants the patient advocate the authority to exercise the patient's right to discharge herself also provides the patient advocate the right to exercise limited additional rights and responsibilities of the patient including the right to confidential medical information,

freedom to present grievances about the patient's medical treatment to governmental officials and anyone else without reprisal by the healthcare facility, private conversations with the patient's lawyer, and the right to inspect the patient's medical records. MCL 333.20201(5). The fact that a patient advocate "may" exercise these rights does not suggest that a patient may not.

Moreover, the next section in the Public Health Code provides that the rights and responsibilities guaranteed in the same section "shall be exercised" by the patient advocate if the patient is "adjudicated incompetent and not restored to legal capacity." MCL 333.20201(6). This language indicates that when a patient has not been adjudicated legally incompetent, the patient and the patient advocate can both exercise the rights guaranteed by MCL 333.20201 including the right to discharge from a nursing home.

For this additional reason, the Court of Appeals' decision should not be reversed.

II. The Court of Appeals did not err by relying upon Attorney Millard's affidavit.

The Court of Appeals did not err by relying on an affidavit submitted by Ms. Roush's attorney pursuant to MCR 2.116(H) to conclude that genuine issues of material fact remained. The Court of Appeals relied upon the affidavit of Attorney Millard to determine that there was a disputed issue of fact regarding whether Ms. Roush was capable of making medical decisions on October 24, 2012. (COA Op 2.) The court could perhaps have better stated that given the potential testimony to be obtained from Dr. Seals, the circuit court should have denied Laurels's motion because it was premature. See MCR 2.116(H)(2). But the result of the Court of Appeals' decision is the same—the case will be remanded for additional discovery including as to whether Ms. Roush was capable of making medical decisions on October 26, 2012.

MCR 2.116(H) provides, in relevant part: "A party may show by affidavit that the facts necessary to support the party's position cannot be presented because the facts are known only to persons whose affidavits the party cannot procure." Although the Michigan courts have not addressed whether an attorney affidavit suffices to oppose summary disposition under this rule, several federal courts have concluded that an attorney affidavit is sufficient with respect to the analogous federal rule, Federal Rule of Civil Procedure 56(d). See *Resolution Trust Corp v North Bridge Assoc, Inc*, 22 F3d 1198, 1204 (CA 1, 1994) (relying on an attorney affidavit to conclude that summary judgment was improper before discovery); *Mathis v GEO Group, Inc*, No 2:08-CT-21-D, 2011 WL 2899135, at *8 n 7 (EDNC, July 18, 2011) (concluding that summary judgment was premature based on an affidavit executed by the plaintiff's attorney). For instance, the First Circuit has reasoned that attorney affidavits should be allowed because a party "would know the relevant particulars only through communications from counsel. Since [the party] could hardly speak either to the cause or the effect of discovery delays, requiring that the supporting affidavit be signed by [the party] rather than by a lawyer would mindlessly exalt form over substance." *Resolution Trust*, 22 F3d at 1204.

The same should be true under MCR 2.116(H). Preventing an attorney from executing an affidavit to avoid premature summary disposition would "mindlessly exalt form over substance." Indeed, even if the party ultimately signs or executes the affidavit, the party's attorney typically drafts the affidavit with the relevant legal and factual arguments. The substance contained within an affidavit is far more important than the person who signs it.

In their Application, Laurels complains that Mr. Millard's affidavit is neither signed nor notarized. (Laurels' Appl'n 19.) Laurels did not raise this issue in the circuit court or the Court

of Appeals. Accordingly, the issue is now waived. See *Walters v Nadell*, 481 Mich 377, 387; 751 NW2d 431 (2008).

Accordingly, the Court of Appeals did not err in relying on the plaintiff's affidavit. As discussed above, even if the Court was to determine that the Court of Appeals erred when it concluded that Attorney Millard's affidavit created a genuine issue of material fact, the error is harmless because the remaining factual issues identified by the court are dispositive.

III. The Court of Appeals properly addressed all of Ms. Roush's claims.

The Court of Appeals did not err in in addressing Ms. Roush's remaining claims of intentional infliction of emotional distress, abuse of process, and civil conspiracy for two reasons: (1) the Court of Appeals did not reach beyond the issues raised on appeal because Ms. Roush appealed the one basis for the circuit court's dismissal all of the plaintiff's claims; and (2) this Court's jurisprudence provides an appellate court with discretion to review a legal issue not raised by the parties.

A. Ms. Roush appealed the circuit court's ruling as to all the claims, and sought reversal as to all her claims, not just her false imprisonment claim.

The Court of Appeals did not err in addressing all of Ms. Roush's causes of action because the circuit court provided only one basis for dismissing the entire case—a basis which the Court of Appeals found to be inapplicable. The circuit court relied exclusively on MCL 700.5508(2) to grant the defendant's motion for summary disposition. (Ex 4, 7/25/2013 Hr'g Tr 30-32.) On appeal, Ms. Roush argued that the circuit court was wrong, and asked the court to reverse the trial court's decision generally and not just with regard to her false imprisonment claim. (Roush Appeal Br 27.) In its appeal brief, Laurels also explained that the circuit court resolved all of Ms. Roush's claims based on MCL 700.5508(2). (Laurels's Appeal

Br 1, 14.) Ms. Roush did not "abandon" any of her claims—she appealed the circuit court's dismissal of all her claims by alleging the circuit court erred as to single basis for the dismissal of each claim.

The Court of Appeals held that application of MCL 700.5508(2) did not resolve any of Ms. Roush's claims. The court explained that the statute was the only basis for the circuit court's dismissal of the intentional-infliction-of-emotional-distress claim, but application of the statute does not resolve that claim. (COA Op 4.) The court separately reached the same conclusion with regard to Ms. Roush's abuse of process and civil conspiracy claims. (*Id.* at 5.) As a result, the Court of Appeals reversed the circuit court's grant of summary disposition in favor of Laurels because the single ground for that decision was insufficient.

Because Ms. Roush did appeal the circuit court's ruling as to all her claims, the Court of Appeals did not err by reversing the circuit court's ruling as to each claim.

B. Appellate courts have inherent discretion to address legal issues not raised by the parties.

The Court of Appeals would not have erred by addressing all four causes of action even if Ms. Roush had not appealed as to all claims because appellate courts have the discretion to review a legal issue not raised by the parties. See *Mack v City of Detroit*, 467 Mich 186, 206-209; 649 NW2d 47 (2002) (holding that the city's failure to raise the issue of governmental immunity did not preclude the Court from considering the issue for the first time on appeal).

This Court has opined that "no one can seriously question the right of this Court to set forth the law as clearly as it can, irrespective [of] whether the parties assist the Court in fulfilling its constitutional function. The jurisprudence of Michigan cannot be, and is not, dependent upon whether individual parties accurately identify and elucidate controlling legal questions." *Id*. at 209. This is true even if the defendants did not have the benefit of briefing or arguing the issue

of before the court. *Id*. at 205. The United States Supreme Court has reached a similar conclusion on several occasions. See, e.g., *Legal Servs Corp v Velazquez*, 531 US 533, 549, 558 (2001) (noting that the determination of whether to address an issue not briefed or contested by the parties is left to the Court's discretion); *Kolstad v Am Dental Ass'n*, 527 US 526, 540 (1999) ("The Court has not always confined itself to the set of issues addressed by the parties."). And based on this principle, the Court of Appeals also reviews legal issues not addressed by the parties in their briefs. See, e.g., *Tingley v Kortz*, 262 Mich App 583, 588; 688 NW2d 291 (2004) (noting that the court "possesses the discretion to review a legal issue not raised by the parties"); *Joerger v Gordon Food Serv, Inc*, 224 Mich App 167, 175; 568 NW2d 365 (1997) (recognizing that although the court did not need to address the trial court's ruling because the plaintiff did not challenge the basis of the trial court's decision, it had the discretion to do so).

It is well-established that "[t]his Court reviews the grant or denial of summary disposition de novo to determine if the moving party is entitled to judgment as a matter of law. In making this determination, the Court reviews the entire record to determine whether defendant was entitled to summary disposition." *Maiden*, 461 Mich at 118 (emphasis added). Based on the Court's de novo review of the entire record, the determination of whether summary disposition was appropriately granted is a legal issue. Because the court "possesses the discretion to review a legal issue not raised by the parties," *Tingley*, 262 Mich App at 588, the Court of Appeals had the discretion to review the legal issue of whether summary disposition was proper as to all of Ms. Roush's causes of action, even if these claims were no more specifically addressed in Ms. Roush's appeal brief than they were in the circuit court's opinion.

Accordingly, Ms. Roush appealed the circuit court's ruling as to all of her causes of action, and the Court of Appeals did not err in addressing all of Ms. Roush's claims.

CONCLUSION AND REQUESTED RELIEF

This case arose because Laurels and its medical director refused to honor Ms. Roush's instructions to discharge her so that she could return to her home. There is no basis under the law for disregarding the directives of a patient about her medical care when she is capable of making medical decisions for herself or when she does not have a patient advocate and has not been adjudicated incompetent. This is true whether the patient is 98 years old, or one-third that age. Yet, that is precisely what Laurels and Dr. Seals did, violating Ms. Roush's fundamental rights to liberty and freedom of movement. The Court of Appeals correctly concluded that Ms. Roush should be entitled to complete discovery on her claims, and then litigate the claims to conclusion.

The Court should deny leave to appeal because there are no issues in this case that are jurisprudentially significant and based on an adequate record. In the alternative, Ms. Roush respectfully requests that the Court affirm the Court of Appeals decision.

Respectfully submitted,

Dated: October 30, 2015

By */s/ Matthew T. Nelson*

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Appendix 1

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Michigan Compiled Laws Annotated
Chapter 333. Health
Public Health Code (Refs & Annos)
Article 17. Facilities and Agencies
Part 201. General Provisions (Refs & Annos)

M.C.L.A. 333.20201

333.20201. Policy regarding rights and responsibilities of patients or residents

Effective: November 8, 2011
Currentness

Sec. 20201. (1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:

(a) A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.

(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271. Except as otherwise permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, [1] or regulations promulgated under that act, 45 CFR parts 160 and 164, [2] a third party shall not be given a copy of the patient's or resident's medical record without prior authorization of the patient or resident.

(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.

(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects

for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(f) A patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice.

(g) A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal. A patient or resident is entitled to information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.

(h) A patient or resident is entitled to information concerning an experimental procedure proposed as a part of his or her care and has the right to refuse to participate in the experimental procedure without jeopardizing his or her continuing care.

(i) A patient or resident is entitled to receive and examine an explanation of his or her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the health facility or agency.

(j) A patient or resident is entitled to know who is responsible for and who is providing his or her direct care, is entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs, and to be involved in his or her discharge planning, if appropriate.

(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.

(m) A patient or resident is entitled to be free from performing services for the health facility or agency that are not included for therapeutic purposes in the plan of care.

(n) A patient or resident is entitled to information about the health facility or agency rules and regulations affecting patient or resident care and conduct.

(o) A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: [3]

(a) The policy shall be provided to each nursing home patient or home for the aged resident upon admission, and the staff of the facility shall be trained and involved in the implementation of the policy.

(b) Each nursing home patient may associate and communicate privately with persons of his or her choice. Reasonable, regular visiting hours, which shall be not less than 8 hours per day, and which shall take into consideration the special circumstances of each visitor, shall be established for patients to receive visitors. A patient may be visited by the patient's attorney or by representatives of the departments named in section 20156, [4] during other than established visiting hours. Reasonable privacy shall be afforded for visitation of a patient who shares a room with another patient. Each patient shall have reasonable access to a telephone. A married nursing home patient or home for the aged resident is entitled to meet privately with his or her spouse in a room that assures privacy. If both spouses are residents in the same facility, they are entitled to share a room unless medically contraindicated and documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(c) A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. Each nursing home patient or home for the aged resident shall be provided with reasonable space. At the request of a patient, a nursing home shall provide for the safekeeping of personal effects, funds, and other property of a patient in accordance with section 21767, [5] except that a nursing home is not required to provide for the safekeeping of a property that would impose an unreasonable burden on the nursing home.

(d) A nursing home patient or home for the aged resident is entitled to the opportunity to participate in the planning of his or her medical treatment. The attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services shall fully inform the nursing home patient of the patient's medical condition unless medically contraindicated as documented in the medical record by a physician or a physician's assistant to whom the physician has delegated the performance of medical care services. Each nursing home patient shall be afforded the opportunity to discharge himself or herself from the nursing home.

(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. [6] A nursing home patient or home for the aged resident

is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.

(f) A nursing home patient or home for the aged resident is entitled to be fully informed before or at the time of admission and during stay of services available in the facility, and of the related charges including any charges for services not covered under title XVIII, or not covered by the facility's basic per diem rate. The statement of services provided by the facility shall be in writing and shall include those required to be offered on an as-needed basis.

(g) A nursing home patient or home for the aged resident is entitled to manage his or her own financial affairs, or to have at least a quarterly accounting of personal financial transactions undertaken in his or her behalf by the facility during a period of time the patient or resident has delegated those responsibilities to the facility. In addition, a patient or resident is entitled to receive each month from the facility an itemized statement setting forth the services paid for by or on behalf of the patient and the services rendered by the facility. The admission of a patient to a nursing home does not confer on the nursing home or its owner, administrator, employees, or representatives the authority to manage, use, or dispose of a patient's property.

(h) A nursing home patient or a person authorized by the patient in writing may inspect and copy the patient's personal and medical records. The records shall be made available for inspection and copying by the nursing home within a reasonable time, not exceeding 1 week, after the receipt of a written request.

(i) If a nursing home patient desires treatment by a licensed member of the healing arts, the treatment shall be made available unless it is medically contraindicated, and the medical contraindication is justified in the patient's medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

(j) A nursing home patient has the right to have his or her parents, if a minor, or his or her spouse, next of kin, or patient's representative, if an adult, stay at the facility 24 hours a day if the patient is considered terminally ill by the physician responsible for the patient's care or a physician's assistant to whom the physician has delegated the performance of medical care services.

(k) Each nursing home patient shall be provided with meals that meet the recommended dietary allowances for that patient's age and sex and that may be modified according to special dietary needs or ability to chew.

(*l*) Each nursing home patient has the right to receive representatives of approved organizations as provided in section 21763. [7]

(4) A nursing home, its owner, administrator, employee, or representative shall not discharge, harass, or retaliate or discriminate against a patient because the patient has exercised a right protected under this section.

(5) In the case of a nursing home patient, the rights enumerated in subsection (2)(c), (g), and (k) and subsection (3)(d), (g), and (h) may be exercised by the patient's representative.

(6) A nursing home patient or home for the aged resident is entitled to be fully informed, as evidenced by the patient's or resident's written acknowledgment, before or at the time of admission and during stay, of the policy required by this section. The policy shall provide that if a patient or resident is adjudicated incompetent and not restored to legal capacity, the rights and

responsibilities set forth in this section shall be exercised by a person designated by the patient or resident. The health facility or agency shall provide proper forms for the patient or resident to provide for the designation of this person at the time of admission.

(7) This section does not prohibit a health facility or agency from establishing and recognizing additional patients' rights.

(8) As used in this section:

(a) “Patient's representative” means that term as defined in section 21703. [8]

(b) “Title XVIII” means title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(c) “Title XIX” means title XIX of the social security act, 42 USC 1396 to 1396w-5.

Credits

Amended by P.A.1982, No. 354, § 1, Imd. Eff. Dec. 21, 1982; P.A.1998, No. 88, Imd. Eff. May 13, 1998; P.A.2001, No. 240, Imd. Eff. Jan. 8, 2002; P.A.2006, No. 38, Imd. Eff. March 2, 2006; P.A.2011, No. 210, Imd. Eff. Nov. 8, 2011.

Footnotes

1 Classified principally to 29 U.S.C.A. § 1181 et seq. For full classification, see U.S.C.A. Tables.

2 45 C.F.R. §§ 160.101 et seq. and 164.102 et seq.

3 M.C.L.A. §§ 333.21301 et seq. and 333.21701 et seq.

4 M.C.L.A. § 333.20156.

5 M.C.L.A. § 333.21767.

6 M.C.L.A. §§ 333.21773 to 333.21777.

7 M.C.L.A. § 333.21763.

8 M.C.L.A. § 333.21703.

M. C. L. A. 333.20201, MI ST 333.20201

The statutes are current through P.A.2015, No. 159 of the 2015 Regular Session, 98th Legislature.

End of Document

Appendix 2

M.C.L.A. 700.5508

700.5508. Patient advocate designation; condition for exercise of powers conferred by patient; determination of condition of patient; authority of advocate to make anatomical gifts

Effective: March 17, 2008
Currentness

Sec. 5508. (1) Except as provided under subsection (3), the authority under a patient advocate designation is exercisable by a patient advocate only when the patient is unable to participate in medical treatment or, as applicable, mental health treatment decisions. The patient's attending physician and another physician or licensed psychologist shall determine upon examination of the patient whether the patient is unable to participate in medical treatment decisions, shall put the determination in writing, shall make the determination part of the patient's medical record, and shall review the determination not less than annually. If the patient's religious beliefs prohibit an examination and this is stated in the designation, the patient must indicate in the designation how the determination under this subsection shall be made. The determination of the patient's ability to make mental health treatment decisions shall be made under section 5515. [1]

(2) If a dispute arises as to whether the patient is unable to participate in medical or mental health treatment decisions, a petition may be filed with the court in the county in which the patient resides or is located requesting the court's determination as to whether the patient is unable to participate in decisions regarding medical treatment or mental health treatment, as applicable. If a petition is filed under this subsection, the court shall appoint a guardian ad litem to represent the patient for the purposes of this subsection. The court shall conduct a hearing on a petition under this subsection as soon as possible and not later than 7 days after the court receives the petition. As soon as possible and not later than 7 days after the hearing, the court shall determine whether or not the patient is able to participate in decisions regarding medical treatment or mental health treatment, as applicable. If the court determines that the patient is unable to participate in the decisions, the patient advocate's authority, rights, and responsibilities are effective. If the court determines that the patient is able to participate in the decisions, the patient advocate's authority, rights, and responsibilities are not effective.

(3) In the case of a patient advocate designation that authorizes a patient advocate to make an anatomical gift of all or part of the patient's body, the patient advocate shall act on the patient's behalf in accordance with part 101 of the public health code, 1978 PA 368, MCL 333.10101 to 333.10123, and may do so only after the patient has been declared unable to participate in medical treatment decisions as provided in subsection (1) or declared dead by a licensed physician. The patient advocate's authority to make an anatomical gift remains exercisable after the patient's death.

Credits

P.A.1998, No. 386, § 5508, Eff. April 1, 2000. Amended by P.A.2003, No. 63, Imd. Eff. July 22, 2003; P.A.2004, No. 532, Imd. Eff. Jan. 3, 2005; P.A.2008, No. 41, Imd. Eff. March 17, 2008.

Footnotes

1 M.C.L.A. § 700.5515.

M. C. L. A. 700.5508, MI ST 700.5508

The statutes are current through P.A.2015, No. 159 of the 2015 Regular Session, 98th Legislature.

End of Document

Appendix 3

M.C.L.A. 700.5509

700.5509. Patient advocate designation; authority, rights, responsibilities, and limitations

Currentness

Sec. 5509. (1) An individual designated as a patient advocate has the following authority, rights, responsibilities, and limitations:

(a) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries in exercising his or her powers.

(b) A patient advocate shall take reasonable steps to follow the desires, instructions, or guidelines given by the patient while the patient was able to participate in decisions regarding care, custody, medical treatment, or mental health treatment, as applicable, whether given orally or as written in the designation.

(c) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(d) The designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(e) A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(f) A patient advocate may choose to have the patient placed under hospice care.

(g) A patient advocate under this section shall not delegate his or her powers to another individual without prior authorization by the patient.

(h) With regard to mental health treatment decisions, the patient advocate shall only consent to the forced administration of medication or to inpatient hospitalization, other than hospitalization as a formal voluntary patient under section 415 of the mental health code, 1974 PA 258, MCL 330.1415, if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to consent to that treatment. If a patient is hospitalized as a formal voluntary patient under an application executed by his or her patient advocate, the patient retains the right to terminate the hospitalization under section 419 of the mental health code, 1974 PA 258, MCL 330.1419.

(2) A patient advocate designation is suspended when the patient regains the ability to participate in decisions regarding medical treatment or mental health treatment, as applicable. The suspension is effective as long as the patient is able to participate in those decisions. If the patient subsequently is determined under section 5508 or 5515 [1] to be unable to participate in decisions regarding medical treatment or mental health treatment, as applicable, the patient advocate's authority, rights, responsibilities, and limitations are again effective.

Credits

P.A.1998, No. 386, § 5509, Eff. April 1, 2000. Amended by P.A.1999, No. 52, Eff. April 1, 2000; P.A.2004, No. 532, Imd. Eff. Jan. 3, 2005.

Footnotes

1 M.C.L.A. §§ 700.5508 to 700.5515.

M. C. L. A. 700.5509, MI ST 700.5509

The statutes are current through P.A.2015, No. 159 of the 2015 Regular Session, 98th Legislature.

End of Document

Appendix 4

M.C.L.A. 700.5510

700.5510. Patient advocate designation; revocation

Effective: March 17, 2008
Currentness

Sec. 5510. (1) A patient advocate designation is revoked by 1 or more of the following:

(a) The patient's death, except that part of the patient advocate designation, if any, that authorizes the patient advocate to make an anatomical gift of all or part of the deceased patient's body in accordance with this act and part 101 of the public health code, 1978 PA 368, MCL 333.10101 to 333.10123.

(b) An order of removal by the probate court under section 5511(5). [1]

(c) The patient advocate's resignation or removal by the court, unless a successor patient advocate has been designated.

(d) The patient's revocation of the patient advocate designation. Subject to section 5515, [2] even if the patient is unable to participate in medical treatment decisions, a patient may revoke a patient advocate designation at any time and in any manner by which he or she is able to communicate an intent to revoke the patient advocate designation. If there is a dispute as to the intent of the patient to revoke the patient advocate designation, the court may make a determination on the patient's intent to revoke the patient advocate designation. If the revocation is not in writing, an individual who witnesses a revocation of a patient advocate designation shall describe in writing the circumstances of the revocation, must sign the writing, and shall notify, if possible, the patient advocate of the revocation. If the patient's physician, mental health professional, or health facility has notice of the patient's revocation of a patient advocate designation, the physician, mental health professional, or health facility shall note the revocation in the patient's records and bedside chart and shall notify the patient advocate.

(e) A subsequent patient advocate designation that revokes the prior patient advocate designation either expressly or by inconsistency.

(f) The occurrence of a provision for revocation contained in the patient advocate designation.

(g) If a patient advocate designation is executed during a patient's marriage naming the patient's spouse as the patient advocate, the patient advocate designation is suspended during the pendency of an action for separate maintenance, annulment, or divorce and is revoked upon the entry of a judgment of separate maintenance, annulment, or divorce, unless the patient has named a

successor individual to serve as a patient advocate. If a successor patient advocate is named, that individual acts as the patient advocate.

(2) The revocation of a patient advocate designation under subsection (1) does not revoke or terminate the agency as to the patient advocate or other person who acts in good faith under the patient advocate designation and without actual knowledge of the revocation. Unless the action is otherwise invalid or unenforceable, an action taken without knowledge of the revocation binds the patient and his or her heirs, devisees, and personal representatives. A sworn statement executed by the patient advocate stating that, at the time of doing an act in accordance with the patient advocate designation, he or she did not have actual knowledge of the revocation of the patient advocate designation is, in the absence of fraud, conclusive proof that the patient advocate did not have actual knowledge of the revocation at the time of the act.

Credits

P.A.1998, No. 386, § 5510, Eff. April 1, 2000. Amended by P.A.2003, No. 63, Imd. Eff. July 22, 2003; P.A.2004, No. 532, Imd. Eff. Jan. 3, 2005; P.A.2008, No. 41, Imd. Eff. March 17, 2008.

Footnotes

1 M.C.L.A. § 700.5511.

2 M.C.L.A. § 700.5515.

M. C. L. A. 700.5510, MI ST 700.5510

The statutes are current through P.A.2015, No. 159 of the 2015 Regular Session, 98th Legislature.

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